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FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6180

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 Film G268 6/7/61 iwk

061 67

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Locust St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary; Middle:; Last: Allen
4. DATE OF DEATH: Month: May; Day: 27; Year: 1961
5. SEX: F
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: October 2, 1874
9. AGE (In years last birthday): 86 yrs. — IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wars or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b) Fracture Lt. Femur.
DUE TO (c)
904.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Fall at home
20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 9:00 5-16 1961
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home.
20f. (City or town) (County) (State): Snow Hill Worcester Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Philip A. Insley M.D.
EXAMINER'S NAME (Type): Philip A. Insley
Address (Street, city, town, or county):
DATE SIGNED: 5-29-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/1/1961
22c. NAME OF CEMETERY OR CREMATORY: Ebenezer
22d. LOCATION (City, town, or country) (State): Bucktown Md

23. FUNERAL DIRECTOR: Clinton F. Stewart
ADDRESS: Salisbury Md.
24a. REC'D BY REGISTRAR DATE JUN 5 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6181

Reg. Dist. No. 06168

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Fruitland
d. STREET ADDRESS: Station Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RAYMOND — Middle BOBBY — Last ALLEN

4. DATE OF DEATH: Month MAY — Day 25 — Year 1961

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 19, 1908
9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months 5 — Days 6
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Vance Co. ~~Virginia~~ N.C.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Sidney Allen
14. MOTHER'S MAIDEN NAME: Hattie Woodleaf

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
INFORMANT: Mr. Bobby Ray Allen (Son) Address: Main St Fruitland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) uremia — INTERVAL BETWEEN ONSET AND DEATH: unknown
443X
DUE TO
(b) Hypertensive cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 5-16, 1961, to 5-25, 1961, that I last saw the deceased alive on 5-25, 1961, and that death occurred at 4 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: William R. Ellis Jr. M.D. — ADDRESS (Street, city or town, state): Salisbury, Md. — DATE SIGNED: 5-25-61

PHYSICIAN'S NAME (Type): Dr. Wilbur R. Ellis Jr. - Medical Center - Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 1, 1961
22c. NAME OF CEMETERY OR CREMATORY: Rock Bridge Cemetery
22d. LOCATION (City, town, or county) (State): Henderson, North Carolina

23. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY — ADDRESS: SALISBURY MARYLAND
24a. REC'D BY REGISTRAR: DATE MAY 29 '61
24b. REGISTRAR'S SIGNATURE: Luther S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6182

Reg. Dist. No. 06169

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 6 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin
d. STREET ADDRESS: West St 23 X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: William — Last: Aydelotte

4. DATE OF DEATH: Month: May — Day: 13 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Nov. 16, 1914

9. AGE (In years last birthday): 46 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chicken Catcher

10b. KIND OF BUSINESS OR INDUSTRY: Poultry

11. BIRTHPLACE (State or foreign country): Berlin MD RFD

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas Aydelotte

14. MOTHER'S MAIDEN NAME: Meta Aydelotte

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 215-20-6588

INFORMANT: Mrs George W. Aydelotte — Address: Berlin Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Spontaneous Subarachnoid Hemorrhage
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

330X

INTERVAL BETWEEN ONSET AND DEATH: 3 da.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5-8, 1961, to 5-13, 1961, that I last saw the deceased alive on 5-13, 1961, and that death occurred at 1:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Walter R. Ellesff M.D. — ADDRESS (Street, city or town, state): Salisbury, Md. — DATE SIGNED: 5-14-61

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 5/16/61

22c. NAME OF CEMETERY OR CREMATORY: Parsons Cem.

22d. LOCATION (City, town, or county) (State): Pittsville Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Anna R. Burbage — ADDRESS: Berlin Md

24a. REC'D BY REGISTRAR — DATE: MAY 16 '61

24b. REGISTRAR'S SIGNATURE: Arthur J. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6183 (6174)

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 4 da.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Delaware
b. COUNTY: Sussex
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frankford Rural
d. STREET ADDRESS: Route # 66
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

46X-3

3. NAME OF DECEASED (Type or print): First: Archie Middle: Allen Last: Baker
4. DATE OF DEATH: Month: 5 Day: 11 Year: 19 61

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 12-26-39
9. AGE (In years last birthday): 21 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Police Officer
10b. KIND OF BUSINESS OR INDUSTRY: Salisbury City
11. BIRTHPLACE (State or foreign country): Selbyville, Del.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Manford Baker
14. MOTHER'S MAIDEN NAME: Addie Baker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes (If yes give war or dates of service): 1958 - 1960
16. SOCIAL SECURITY NO.: 222-24-4227
17. INFORMANT: Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral hemorrhage	3 days
DUE TO (b)	Fracture of skull	3 days
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car that ran off road.
20c. TIME OF INJURY: Hour 3:05 a.m. p.m. Month, Day, Year: P.M. 5-8-61
20d. INJURY OCCURRED: While at work [ ] Not While at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway #66
20f. (City or town): Frankfort (County): Sussex (State): Del.

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Earl L. Royer M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: 5-14-61
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 407 Camden Ave. Salisbury, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-14-61
22c. NAME OF CEMETERY OR CREMATORY: McChandes
22d. LOCATION (City, town, or country): Millsboro (State): Del.

23. FUNERAL DIRECTOR: Henry H. Watson ADDRESS: Pocomoke City, Md.
Henry W. Watson Selbyville, Del.

24a. REC'D BY REGISTRAR: DATE MAY 18 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6184

CERTIFICATE OF DEATH

Reg. Dist. No. 06171

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Princess Anne Md.
d. STREET ADDRESS: 19X-9
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: William — Middle: Harold — Last: BEDSWORTH

4. DATE OF DEATH: Month: MAY — Day: 12 — Year: 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: Sept 30, 1898

9. AGE (In years lost birthday): 62 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Henry Bedsworth

14. MOTHER'S MAIDEN NAME: Elia Tyler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown):
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Louise Bedsworth — Address: Princess Anne R#3

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSE BY:
IMMEDIATE CAUSE (a): Pulmonary Embolism due
DUE TO (b): to Thrombophlebitis
DUE TO (c):

464

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] **OR CONTRIBUTING** [ ] **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State):

21. I certify that I attended the deceased from 5-8, 1961, to 5-12, 1961, that I last saw the deceased alive on 5-12, 1961, and that death occurred at 11 20 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE William B. Ellis Jr. M.D. — **ADDRESS** (Street, city or town, state): Salisbury, Md. — **DATE SIGNED**: 5-14-61

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **22b. DATE THEREOF**: 5/15/61 — **22c. NAME OF CEMETERY OR CREMATORY**: Oriole — **22d. LOCATION** (City, town, or county) (State): Oriole Md

23. FUNERAL DIRECTOR'S SIGNATURE: Ames Wineman — **ADDRESS**: Princess Anne

24a. REC'D BY REGISTRAR DATE MAY 18 '61 — **24b. REGISTRAR'S SIGNATURE**: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6185

CERTIFICATE OF DEATH

Reg. Dist. No. 16172

M

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 3 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital
d. STREET ADDRESS: 511 MARKET STREET

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): POCOMOKE CITY
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARGARET Middle LUCUS Last Bowen

4. DATE OF DEATH: Month May Day 5 Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: AUGUST 1, 1877
9. AGE (In years lost birthday): 83 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

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13. FATHER'S NAME: OLIVER J. LUCUS
14. MOTHER'S MAIDEN NAME: EMMA W. MATTHEWS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: NONE
INFORMANT: MRS S. M. CROCKETT, Address 410 MARKET ST. POCOMOKE CITY, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cerebral Arteriosclerosis
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Essential Hypertension
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5/2, 1961, to 5/5, 1961, that I last saw the deceased alive on 5/5, 1961, and that death occurred at 10:55 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: David J. Gilmore M.D. ADDRESS (Street, city or town, state): Salisbury Md DATE SIGNED: 5/5/61

PHYSICIAN'S NAME (Type): DAVID J. GILMORE

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 5-7-61
22c. NAME OF CEMETERY OR CREMATORY: BETHANY METHODIST
22d. LOCATION (City, town, or county) (State): POCOMOKE CITY, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: Robert H. Watson ADDRESS: POCOMOKE CITY, MD.
24a. REC'D BY REGISTRAR DATE MAY 8 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6186

CERTIFICATE OF DEATH

Reg. Dist. No. 06173

1. PLACE OF DEATH
a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): White Haven
c. LENGTH OF STAY IN 1b: 3 wks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oriole 19 X -2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sarah Middle: R. Last: Bozman

4. DATE OF DEATH: Month: May Day: 15 Year: 1961

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan. 23, 1876
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Jones
14. MOTHER'S MAIDEN NAME: Mary Windsor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Van Muir Address: Monie, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	uremia	2-3 wks
DUE TO	cardiac	
(b)	failure DA compensation	2-3 mo.
DUE TO		
(c)	arteriosclerosis - hypertension	5 yr

444X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5/1, 1961, to 5/15, 1961, that I last saw the deceased alive on 5/15, 1961, and that death occurred at 4 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Barbara Hunt M.D. ADDRESS (Street, city or town, state): Hartsville, Md. DATE SIGNED: 5/16/61

PHYSICIAN'S NAME (Type): Barbara Hunt

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-17-1961
22c. NAME OF CEMETERY OR CREMATORY: Oriole Cemetery
22d. LOCATION (City, town, or county) (State): Oriole, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Levin R. Wilson ADDRESS: Princess Anne, Md.
24a. REC'D BY REGISTRAR DATE: MAY 22 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6187

CERTIFICATE OF DEATH

06174

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hebron (Rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R.D.# 1

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hebron (Rural)
d. STREET ADDRESS: R.D.# 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First WILLIAM Middle THOMAS Last BYRD
4. DATE OF DEATH: Month MAY Day 10th Year 19 61
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: April 19, 1878
9. AGE (In years last birthday): 83 yrs. IF UNDER 1 YEAR: Months 0 Days 21 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Quantico, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Thomas James Byrd
14. MOTHER'S MAIDEN NAME: Mary Jane Cooper
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Minnie E. Byrd (Wife) Address R.D.#1 Hebron, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b): arteriosclerosis
DUE TO
(c):

332 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Previous cerebral hemorrhage ~ hemiplegia
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A
20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. N/A 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): N/A
20f. (City or town) (County) (State): N/A

21. I certify that (I) (this hospital) attended the deceased from 2/4 19 58 to death 19 ____, that (I) (we) last saw the deceased alive on 5/9 19 61, and that death occurred at 6P M, from the causes and on the date stated above.

22a. SIGNATURE: Ernest Larmore M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: May 12 1961
22c. PHYSICIAN'S NAME (Type): Dr. Ernest M. Larmore
22d. ADDRESS: Delmar, Delaware

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 12, 1961
23c. NAME OF CEMETERY OR CREMATORY: Quantico Cemetery
23d. LOCATION (City, town, or county) (State): Quantico, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY ADDRESS: SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR DATE: MAY 16 '61
25b. REGISTRAR'S SIGNATURE: Arthur E. Kimes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6188

CERTIFICATE OF DEATH

06175

Item 9 Film 6288 6/2/61 LWS

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 3Mos.1Day
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: R.D.#5 Pemberton Drive
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: John — Middle: Wesley — Last: Carter
4. DATE OF DEATH: Month: May — Day: 27 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: April 25, 1869
9. AGE (In years last birthday): 92 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unk. (Retired Farmer)
10b. KIND OF BUSINESS OR INDUSTRY: Unk.
11. BIRTHPLACE (County & State, or foreign country): Worcester, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Wesley Carter
14. MOTHER'S MAIDEN NAME: ~~xxxx~~ Elizabeth Pusey
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Unk
16. SOCIAL SECURITY NO.: Unk.
17. INFORMANT: Mr. Lawrence J. Carter (Son) Address: R.D.# 5 Sal. Md.
Hospital Records -- Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilateral bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 d.
491X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2/23/61, 19..., to 5/27/61, 19..., that (I) (we) last saw the deceased alive on 5/27/61 19..., and that death occured at 12:20 AM, from the causes and on the date stated above.

22a. SIGNATURE: L. Maldve, M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: May 27, 1961
22c. PHYSICIAN'S NAME (Type): L. Maldve, M.D.
22d. ADDRESS: Deer's Head State Hospital--Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 31, 1961
23c. NAME OF CEMETERY OR CREMATORY: Olivet Cemetery
23d. LOCATION (City, town or county) (State): Worcester Co. Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY — ADDRESS: SALISBURY MARYLAND
25a. REC'D BY REGISTRAR — DATE: MAY 31 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

I

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6189

CERTIFICATE OF DEATH

Reg. Dist. No. 16176

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

c. LENGTH OF STAY IN 1b: 15 yrs.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 311 Broad Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

d. STREET ADDRESS: 311 Broad Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Jesse Middle: Last: Chapman

4. DATE OF DEATH Month: 5 Day: 18 Year: 1961

5. SEX: M

6. COLOR OR RACE: AA

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Not positive

9. AGE (In years last birthday): 58 yrs.

IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Not known

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Not known

14. MOTHER'S MAIDEN NAME: Not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.

INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Cirrhosis — INTERVAL BETWEEN ONSET AND DEATH: Unknown

581.0

DUE TO (b) Usual Causes — Unk.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Not Known

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 15, 1961, to May 18, 1961 that I last saw the deceased alive on May 18, 1961, and that death occurred at 12:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: G. Herbert Sembly M.D. ADDRESS (Street, city or town, state): 400 E. Church St. Salisbury DATE SIGNED: 5/18/61

PHYSICIAN'S NAME (Type): Herbert G. Sembly 400 East Church St., Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

22b. DATE THEREOF: 5-19-61

22c. ~~NAME OF CEMETERY OR CREMATORY~~: Md. Anatomical Bd.

22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Thornton B. Jelley ADDRESS: Salisbury, Md

24a. REC'D BY REGISTRAR DATE: MAY 24 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B

1

M

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6190

CERTIFICATE OF DEATH

Reg. Dist. No. 06177

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 408 Stewarts Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George; Middle:; Last: Collins

4. DATE OF DEATH: Month: May; Day: 8; Year: 1961

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 21, 1890

9. AGE (In years lost birthday): 70 yrs.

IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Collins

14. MOTHER'S MAIDEN NAME: Mary Corbin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Bessie Ellis — Address: 420 Stewart Place Salisbury Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
610 X
DUE TO (b): Benign Prostatic Hypertrophy
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 2, 1961, to May 8, 1961, that I last saw the deceased alive on May 7, 1961, and that death occurred at 8:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H. Gray Reeves M.D. — ADDRESS (Street, city or town, state): H. Gray Reeves Medical Clinic Salisbury, Md. — DATE SIGNED: 9 May 61

PHYSICIAN'S NAME (Type): H. Gray Reeves, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/13/1961

22c. NAME OF CEMETERY OR CREMATORY: Glass Hill

22d. LOCATION (City, town, or county): Parsonsburg (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Clinton E. Stewart — ADDRESS: Salisbury Md.

24a. REC'D BY REGISTRAR: DATE MAY 15 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6191

CERTIFICATE OF DEATH

Reg. Dist. No. 06178

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X DELMAR
d. STREET ADDRESS: 301 CHESTNUT
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Lee — Middle: Hobarth — Last: Cox
4. DATE OF DEATH: Month: May — Day: 27 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 2-29-1880
9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ENGINEER
10b. KIND OF BUSINESS OR INDUSTRY: RAILROAD
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: FRANK COX
14. MOTHER'S MAIDEN NAME: PRISCILLA TWIGG
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 716-03-1653
INFORMANT: RAYMOND COX — Address: LAUREL DEL

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b) Diabetes Mellitus — ? years
DUE TO (c)
260X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from 26-MAY, 1961, to 27 MAY, 1961, that I last saw the deceased alive on 27 MAY, 1961, and that death occurred at 2:35 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph C. Fitzgerald M.D. — ADDRESS (Street, city or town, state): — DATE SIGNED: 5/27/61
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 2-29-61
22c. NAME OF CEMETERY OR ~~CREMATORY~~: M-E
22d. LOCATION (City, town, or county) (State): DELMAR - DEL

23. FUNERAL DIRECTOR'S SIGNATURE: W. S. Mamalo — ADDRESS: Delmar Del
24a. REC'D BY REGISTRAR: DATE MAY 31 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Travers

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6192

CERTIFICATE OF DEATH

Reg. Dist. No. 06179

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DELMAR
d. STREET ADDRESS: R7 D.
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

M

082

3. NAME OF DECEASED (Type or print): First EDWARD Middle BLOXOM Last DAUGHERTY Sr.

4. DATE OF DEATH: Month MAY Day 16 Year 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☑ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 3-7-1892

9. AGE (In years last birthday): 69 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CONDUCTOR

10b. KIND OF BUSINESS OR INDUSTRY: RAILROAD

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: GEORGE DAUGHERTY

14. MOTHER'S MAIDEN NAME: MARY EDNA BLOXOM

I

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 216-01-6890

INFORMANT: DELLA DAUGHERTY — Address: DELMAR MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 months
420.0
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 12, 1961, to May 16, 1961, that I last saw the deceased alive on May 15, 1961, and that death occurred at 3:20 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE David J. Gilmore M.D. — **ADDRESS** (Street, city or town, state): Salisbury Md. — **DATE SIGNED**: May 16, 1961

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5-18-61

22c. NAME OF CEMETERY OR CREMATORY: Mt Olive

22d. LOCATION (City, town, or county) (State): Delmar Del

23. FUNERAL DIRECTOR'S SIGNATURE — **ADDRESS**: W. S. Mason Co. Delmar, Del

24a. REC'D BY REGISTRAR DATE MAY 18 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6193

CERTIFICATE OF DEATH

Reg. Dist. No. 06180

M

1. PLACE OF DEATH b. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 4 HRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X WILLARDS
d. STREET ADDRESS: 1 MAIN St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: BESSIE Middle: CATHERINE Last: Dennis
4. DATE OF DEATH: Month: May Day: 9 Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 15, 1903
9. AGE (In years lost birthday): 57 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Mitchell Davis
14. MOTHER'S MAIDEN NAME: Anna Hall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
INFORMANT: Mrs. G.C. Bounds Address: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction — 5 hours
DUE TO
(b) Coronary Arteriosclerosis — 1 year
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August, 1960 to May 9, 1961, that I last saw the deceased alive on May 8, 1961, and that death occurred at 1:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas C. Hill Jr. M.D. — ADDRESS (Street, city or town, state): Pine Bluff Road Salisbury, Md — DATE SIGNED: 5/9/61

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 5/11/1961
22c. NAME OF CEMETERY OR CREMATORY: DENNIS CEMETERY
22d. LOCATION (City, town, or county) (State): WILLARDS, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: Hill & Johnson Co. — ADDRESS: Salisbury, Md.
George C. Hill
24a. REC'D BY REGISTRAR — DATE: MAY 12 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

6194

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06181

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
d. STREET ADDRESS: 21 Barley Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

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082

23X-2

3. NAME OF DECEASED (Type or print): First: Nettie; Middle: Henrietta; Last: Dennis

4. DATE OF DEATH: Month: MAY; Day: 15; Year: 1961

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5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Nov. 30, 1877

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Berlin MD RFD

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Brittingham

14. MOTHER'S MAIDEN NAME: Hester Anne Timmons

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: No

INFORMANT: Mrs. Elsie Maynard — Address: Tarpon Springs, Fla.

FLA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma Breast — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs
DUE TO (b)
DUE TO (c)

170X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

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21. I certify that I attended the deceased from 5/2, 1961, to 5/15, 1961, that I last saw the deceased alive on 5/15, 1961, and that death occurred at 8:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John M. Bloxom III M.D. — ADDRESS (Street, city or town, state): Medical Center — DATE SIGNED: 5/15/1961

PHYSICIAN'S NAME (Type): JOHN M. BLOXOM III — SALISBURY, MD

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/18/61

22c. NAME OF CEMETERY ~~OR CREMATORY~~: Evergreen

22d. LOCATION (City, town, or county): Berlin (State): MD

23. FUNERAL DIRECTOR'S SIGNATURE: Anna A. Burbage — ADDRESS: Berlin Md.

24a. REC'D BY REGISTRAR DATE: MAY 18 '61

24b. REGISTRAR'S SIGNATURE: Christine S. Finess

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/5B

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6195

Reg. Dist. No. 06182

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Worcester Co
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin
d. STREET ADDRESS: Flower St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First — Middle — Last: Herrickson
4. DATE OF DEATH: Month: May — Day: 29 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH:
9. AGE (In years lost birthday) yrs.: IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Salisbury Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Mansfield Herrickson
14. MOTHER'S MAIDEN NAME: Bobora Conway
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
INFORMANT: Mansfield Herrickson — Address: Berlin

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Prematurity — 15½ oz Birth wt
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

773.5

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 29, 1961, to May 29, 1961 that I last saw the deceased alive on May 29, 1961, and that death occurred at 10 45 pM, from the causes and on the date stated above.

ACTUAL SIGNATURE: William C. Morgan M.D. — ADDRESS (Street, city or town, state): — DATE SIGNED: 5/30/61

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 31 1961
22c. NAME OF CEMETERY OR CREMATORY: Evergreen Cem
22d. LOCATION (City, town, or county) (State): Berlin Md

23. FUNERAL DIRECTOR'S SIGNATURE: Booker M. West — ADDRESS:
24a. REC'D BY REGISTRAR DATE JUN 5 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

2082272XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

.1

6196

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06183

M

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 8 Months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pleasant Care Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pinehurst
d. STREET ADDRESS: 23X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

090

3. NAME OF DECEASED (Type or print): First: Nellie — Middle: E. — Last: Dickerson

4. DATE OF DEATH: Month: May — Day: 31 — Year: 1961

I

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 10/30-1890
9. AGE (In years last birthday): 70/6/1 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Cape Charles, Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Dickerson
14. MOTHER'S MAIDEN NAME: Jane Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs Janine Hartsuff, 3 Old Skyhill Rd, Alexandria, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease
DUE TO (b): Diabetes Mellitus
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

260X

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/60 19__, to 5/31/61 19__, that (I) (we) last saw the deceased alive on 5/29/61 19__, and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: A C Mitchell M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/31/61
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: Salisbury, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 2/61
23c. NAME OF CEMETERY OR CREMATORY: Spring Hill Cemetery
23d. LOCATION (City, town, or county) (State): Pinehurst, Md

24. FUNERAL DIRECTOR'S SIGNATURE: Allen E. Timmons
ADDRESS: Snow Hill, Md
25a. REC'D BY REGISTRAR: DATE JUN 5 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6197

Reg. Dist. No. 06184

M

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 322 Naylor St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NETTIE Middle ELLEN Last DRYDEN

4. DATE OF DEATH: Month MAY Day 3 Year 1961

I

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 5, 1889
9. AGE (In years lost birthday): 71 yrs. IF UNDER 1 YEAR: Months 7 Days 28 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work at Home
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Delmar, Delaware
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Thomas B. Calloway
14. MOTHER'S MAIDEN NAME: Laura Beach

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
INFORMANT: Mr. J. Howard Dryden (Husband) Address: 322 Naylor St Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2-3 days
DUE TO (b)
493X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year N/A 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): N/A
20f. (City or town) (County) (State): N/A

21. I certify that I attended the deceased from 4/11, 1961, to 5/3, 1961, that I last saw the deceased alive on 5/2/61, 19, and that death occurred at 2 a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Fred R. Gramse M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED: May 3, 1961

PHYSICIAN'S NAME (Type): Dr. Fred R. Gramse — S. Division St. Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May. 5, 1961
22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND
24a. REC'D BY REGISTRAR DATE MAY 9 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6198 06185

1. PLACE OF DEATH a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 12
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 306 Buena Vista Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 306 Buena Vista Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NATHAN Middle JAMES Last FOSKEY
4. DATE OF DEATH: Month MAY Day 19th Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 16, 1890
9. AGE (In years last birthday): 71 yrs. IF UNDER 1 YEAR: Months 2 Days 3 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Mason
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Pittsville, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Nathan Henry Foskey
14. MOTHER'S MAIDEN NAME: Henrietta Miller
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Charlie H. Foskey (Son) Address S. Division St Ext Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Rupture - abdominal aneurysm — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.
DUE TO
451X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) generalized arteriosclerosis — 7 yrs.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. N/A 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): N/A
20f. (City or town) (County) (State): N/A

21. I certify that (I) (this hospital) attended the deceased from 12/26 1958 to 5/19 1961, that (I) (we) last saw the deceased alive on 5/19 1961, and that death occurred at App. 10:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Earl M. Beardsley M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: May 22/1961
22c. PHYSICIAN'S NAME (Type): Dr. Earl M. Beardsley
22d. ADDRESS: Maryland Ave. Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 23, 1961
23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
23d. LOCATION (City, town, or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY ADDRESS: SALISBURY MARYLAND
25a. REC'D BY REGISTRAR DATE MAY 25 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kane

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

1

FOR STATE HEALTH DEPT.

M

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6199 — 06186

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fruitland (Rural-Salisbury)
d. STREET ADDRESS: 132 Clyde Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Thomas — Last: Foskey
4. DATE OF DEATH: Month 5 — Day 22 — Year 61
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec.24,1929
9. AGE (In years last birthday): 31 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Line-man, Employee of
10b. KIND OF BUSINESS OR INDUSTRY: E. S. P. S.
11. BIRTHPLACE (State or foreign country): Salisbury, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: William W. Foskey
14. MOTHER'S MAIDEN NAME: Nellie Frances Foskey
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Unk — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 220-12-1874
17. INFORMANT: Mrs. Betty L. Foskey (Wife) (Fruitland) — Address: 132 Clyde Ave. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Electrocution — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

914.3

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Working on pole and touched wire with 12,000 Volts.
20c. TIME OF INJURY: Hour a.m. 10:05 A.M. — Month, Day, Year 5-22-61
20d. INJURY OCCURRED: While at work ☒ — Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Quantico Road
20f. (City or town): Salisbury — (County): Wicomico — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 407 Camden Ave. Salisbury, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 5-23-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 25,1961
22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
22d. LOCATION (City, town, or country): Salisbury, Maryland — (State): Maryland

23. FUNERAL DIRECTOR: HOLLOWAY & COMPANY — ADDRESS: SALISBURY MARYLAND
24a. REC'D BY REGISTRAR — DATE: MAY 25 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

1
FOR STATE HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6200

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06187

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 111 Jenkins Lane
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Wesley — Last: Harmon
4. DATE OF DEATH: Month: 5 — Day: 8 — Year: 19 61

5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MAY 31 1913
9. AGE (In years last birthday): 47+8 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Somerset Co
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LEWIS HARMON
14. MOTHER'S MAIDEN NAME: ~~Lettie Harmon~~ LIZZIE BARKLEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 212-12-3329
17. INFORMANT: Lettie Harmon — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
443X
IMMEDIATE CAUSE (a) Acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cerebral vascular accident — Sudden
DUE TO
(c) Hypertensive cardio-vascular disease — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 5-10-61
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 407 Camden Ave. Salisbury, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-11-61
22c. NAME OF CEMETERY OR CREMATORY: Flower Hill
22d. LOCATION (City, town, or country) (State): Eden, Md.

23. FUNERAL DIRECTOR: Booker M. West
ADDRESS: 130 Second
24a. REC'D BY REGISTRAR DATE: MAY 15 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Travers

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6201 06188

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 16 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R.D. Golts (Sassafras)
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: — Last: Hart

4. DATE OF DEATH: Month: May — Day: 26 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 7/20/1876

9. AGE (In years last birthday): 84 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Kent County Chesterville, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: Eva Single

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Deer's Head Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
(b) Generalized arteriosclerosis — 10 yrs.
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/10/, 1961, to 5/26/, 1961, that (I) (we) last saw the deceased alive on 5/25/, 1961, and that death occured at 7 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Lee L Lawry M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 5/26/61

22c. PHYSICIAN'S NAME (Type): LEE L. LAWRY, M. D.

22d. ADDRESS: Deer's Head State Hospital, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): 5-31.61 U

23b. DATE THEREOF:

23c. NAME OF CEMETERY OR CREMATORY: Md. Med. School

23d. LOCATION (City, town or county) (State): Baltimore, Md.

24 FUNERAL DIRECTOR'S SIGNATURE:

ADDRESS:

25a. REC'D BY REGISTRAR DATE JUN 1 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6202

CERTIFICATE OF DEATH

Reg. Dist. No. 06189

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 2hs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: DELAWARE
b. COUNTY: SUSSEX
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DELMAR
d. STREET ADDRESS: GROVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First WILLIAM Middle PURNELL Last Hastings
4. DATE OF DEATH: Month MAY Day 2 Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 9-20-1892
9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BARBER
10b. KIND OF BUSINESS OR INDUSTRY: BARBER
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Frederick Hastings
14. MOTHER'S MAIDEN NAME: Mary Taylor
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW1
16. SOCIAL SECURITY NO.: 217-10-2150
INFORMANT: Lois Carr — Address: Delmar Del

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Strangulated Incisional Hernia with Peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

561.3

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 5-2, 1961, to 5-2, 1961, that I last saw the deceased alive on 5-2, 1961, and that death occurred at 10:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William R. Ellis, Jr. M.D. — ADDRESS (Street, city or town, state): Salisbury, Md. — DATE SIGNED: 5-2-61

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-4-61
22c. NAME OF CEMETERY OR ~~CREMATORY~~: Parsons
22d. LOCATION (City, town, or county) (State): Salisbury, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: W. S. Mears Co. — ADDRESS: Delmar, Del.
24a. REC'D BY REGISTRAR DATE MAY 4 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Krupa

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

6203

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 46190

M

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 3 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 121 Holland Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 121 Holland Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First VERNON Middle MARSHALL Last HAYES

4. DATE OF DEATH: Month May Day 5 Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan 12, 1907
9. AGE (In years lost birthday): 54 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Asst. Manager
10b. KIND OF BUSINESS OR INDUSTRY: Life Insurance
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William Franklin Hayes
14. MOTHER'S MAIDEN NAME: Elvira Knapp

I

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): W.W. II
16. SOCIAL SECURITY NO.: 212-15-3133
INFORMANT: Address: Mrs. V. M. Hayes, 121 Holland Ave., Salisbury

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Artery Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: approx 2 yr.
4201
DUE TO (b) Coronary Artery Atherosclerosis — —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 13, 1959, to May 5, 1961, that I last saw the deceased alive on May 5, 1961, and that death occurred at 11 30 a. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: David J Gilmore M.D. ADDRESS (Street, city or town, state): Salisbury Md DATE SIGNED: May 8, 1961
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/9/61
22c. NAME OF CEMETERY OR CREMATORY: Sunny Slope Cemetery
22d. LOCATION (City, town, or county) (State): West Point, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: George C. Hill II
ADDRESS: Hill and Johnson Co. 705 E. Main St, Salisbury Md
24a. REC'D BY REGISTRAR: MAY 10 '61
24b. REGISTRAR'S SIGNATURE: Esther L. Pruitt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6204

Reg. Dist. No. 06191

M

1. PLACE OF DEATH a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dalmar
c. LENGTH OF STAY IN 1b: IO Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Daimar
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

X

3. NAME OF DECEASED (Type or print): First Garland Middle Last Hayward
4. DATE OF DEATH: Month 5 Day 25 Year 19 6I

I

5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/5/I947
9. AGE (In years last birthday): I4 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U S A.
13. FATHER'S NAME: William Shreeves
14. MOTHER'S MAIDEN NAME: Hortense Hayward
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hortense Shreeves Address: Delmar, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Basilar fracture Skull & Brain Stem injury — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
813 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) automobile accident collision with deceased who was riding a bicycle
20c. TIME OF INJURY: Hour 9 a. m. p. m. Month, Day, Year 5-25 1961
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 13.
20f. (City or town) (County) (State) Wicomico. Md

22

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

2

ACTUAL SIGNATURE: Philip A. Insley M.D.
EXAMINER'S NAME (Type): Philip A. Insley
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 5-26-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/30/6I
22c. NAME OF CEMETERY OR CREMATORY: Christ M.E.
22d. LOCATION (City, town, or county) (State): Bunch And landing, Md
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: William H. James Jr, Princess Anne, Md
24a. REC'D BY REGISTRAR DATE JUN 5 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

1

M

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6205

CERTIFICATE OF DEATH

Reg. Dist. No. 06192

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Accomack
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wattsville
d. STREET ADDRESS: 83 X-3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rae — Middle: Virginia — Last: Hinmon

4. DATE OF DEATH: Month: May — Day: 16 — Year: 1961

5. SEX: F
6. COLOR OR RACE: Col
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-9-14
9. AGE (In years last birthday): 46 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Harmon
14. MOTHER'S MAIDEN NAME: Ethel Bivins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 213 18 4165
INFORMANT: John S. Hinmon — Address: Wattsville, Va.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
442X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/16, 1961, to 5/16, 1961, that I last saw the deceased alive on 5/15, 1961, and that death occurred at 4 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Klaird J. Gilmore M.D. — ADDRESS (Street, city or town, state): Salisbury, Maryland — DATE SIGNED: 5/16/61

PHYSICIAN'S NAME (Type): David J. Gilmore

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-21-61
22c. NAME OF CEMETERY OR CREMATORY: Wattsville Methodist
22d. LOCATION (City, town, or county) (State): Wattsville, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: J. E. Thomas Funeral Home — ADDRESS: Accomac, Va.
24a. REC'D BY REGISTRAR: DATE MAY 22 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6206

CERTIFICATE OF DEATH

06193

M

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pen Gen Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 512 Washington St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

082

3. NAME OF DECEASED (Type or print): First SADIE — Middle LEE — Last JOHNSON
4. DATE OF DEATH: Month MAY — Day 28th — Year 19 61

I

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: August 22, 1884
9. AGE (In years last birthday): 76 yrs. — IF UNDER 1 YEAR: Months 9, Days 8 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work at Home
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Nanticoke, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Columbus Moore
14. MOTHER'S MAIDEN NAME: Sarah Webster

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Stomach Ulcer with Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days
540.0
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year: N/A 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): N/A
20f. (City or town) (County) (State): N/A

21. I certify that (I) (this hospital) attended the deceased from 1956 19__ to 5/28 19 61, that (I) (we) last saw the deceased alive on 5/28/61 19__, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Fred R. Gramse M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: May 29 / 1961
22c. PHYSICIAN'S NAME (Type): Dr. Fred R. Gramse
22d. ADDRESS: S. Division St Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 1, 1961
23c. NAME OF CEMETERY OR CREMATORY: Wicomico Mem. Park
23d. LOCATION (City, town, or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY — ADDRESS: SALISBURY MARYLAND
25a. REC'D BY REGISTRAR — DATE: MAY 31 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6207 — 66194

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury, Maryland
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Vienna, Maryland
d. STREET ADDRESS: Rt. 1 Box 113
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

09X-2

3. NAME OF DECEASED (Type or print): First: Elmer — Middle: T. — Last: Jones

4. DATE OF DEATH: Month: May — Day: 27 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: Aug. 5, 1910

9. AGE (In years last birthday): 50 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (County & State, or foreign country): Dorchester County, Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Theodore Jones

14. MOTHER'S MAIDEN NAME: Florence Molock

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): -------

16. SOCIAL SECURITY NO.: 215-12-6051

17. INFORMANT: Arelia Jones, Address: RrD.1 Vienna, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Recurrent Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 min.
DUE TO (b): Cerebral A. S. — Years
DUE TO (c): Arteriosclerosis General — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

332X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May 22, 19 61 to May 27, 19 61 that (I) (we) last saw the deceased alive on May 27, 19 61, and that death occured at 6 P.M. from the causes and on the date stated above.

22a. SIGNATURE: L. Maldve, M.D.

ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]

22b. DATE SIGNED: May 28, 1961

22c. PHYSICIAN'S NAME (Type): L. Maldve, M.D.

22d. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/31/1961

23c. NAME OF CEMETERY OR CREMATORY: Aireys Cemetery

23d. LOCATION (City, town or county) (State): Dorchester County, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert M. Tolson Jr. — ADDRESS: Cambridge, Md.

25a. REC'D BY REGISTRAR — DATE: MAY 31 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

1

Item 20 Film 288
6-15-61 ame

6208

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06195

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Mardela
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R.D.#(Maple Shad Nursing Home) In Village

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Powellville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNIE Middle BELLE Last KELLY
4. DATE OF DEATH: Month MAY Day 10th Year 19 61
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 22,1880
9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months 8 Days 18 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work at Home
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Powellville, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Charles Bethards
14. MOTHER'S MAIDEN NAME: Sallie Crowley
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr.Henry P.Kelly(Husband) Address: Powellville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Femur — INTERVAL BETWEEN ONSET AND DEATH: 3 months
904.0
DUE TO (b) Thrombo phlebitis — 2 month
DUE TO (c) Pneumonia Lobar — 2 weeks
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell in home
20c. TIME OF INJURY Hour 6 a. m. p. m. Month, Day, Year Feb 25 1961
20d. INJURY OCCURRED While at work ☒ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home
20f. (City or town) Powellville (County) Wic. (State) Md.

21. I certify that (I) (this hospital) attended the deceased from March 1961 to May 10 1961, that (I) (we) last saw the deceased alive on May 10 1961, and that death occurred at 6:40 P. M. from the causes and on the date stated above.

22a. SIGNATURE: H S Kuhlman M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: May 12 1961
22c. PHYSICIAN'S NAME (Type): Dr.H.S.Kuhlman
22d. ADDRESS: Sharptown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 13,1961
23c. NAME OF CEMETERY OR CREMATORY: St.Johns Cemetery
23d. LOCATION (City, town, or county) (State): Powellville, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY ADDRESS: SALISBURY MARYLAND
25a. REC'D BY REGISTRAR DATE MAY 16 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
ISM 9/59

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any data is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6209 — 06196

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Eden
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Route # 2

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Eden
d. STREET ADDRESS: Route # 2
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First Kay, Middle Frances, Last King
4. DATE OF DEATH: Month 5, Day 7, Year 19 61
5. SEX: F
6. COLOR OR RACE: WC
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 12-31-60
9. AGE (In years last birthday): 4 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Oliver King
14. MOTHER'S MAIDEN NAME: Sarah Wessels
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Father: Oliver King, Eden, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

924.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Infant sleeping in double bed with parents found dead in A.M.
20c. TIME OF INJURY: Hour 6 a.m. Month, Day, Year 5-7-61 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town): Eden (County): Wicomico (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [X]

ACTUAL SIGNATURE: Earl L. Royer, M.D.
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 407 Camden Ave. Salisbury, Md.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: 5-11-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-8-61
22c. NAME OF CEMETERY OR CREMATORY: Friendship Cem
22d. LOCATION (City, town, or country): Allen, Md.
23. FUNERAL DIRECTOR: Thornton B. Jolley, ADDRESS: Salisbury, Md
24a. REC'D BY REGISTRAR: DATE MAY 25 '61
24b. REGISTRAR'S SIGNATURE: Arthur E. Kruse

20822216XV3

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6210 06197

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pen Gen Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Salisbury
d. STREET ADDRESS: R.D.# 3(Delmar Rd)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BABY Middle BOY Last LAMB
4. DATE OF DEATH: Month MAY Day 4th Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 3,1961 2:28A.M.
9. AGE (In years last birthday): 0 yrs. IF UNDER 1 YEAR: Months 0 Days 0 IF UNDER 24 HRS.: Hours 23 Min. 42

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Salisbury,Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Unk
14. MOTHER'S MAIDEN NAME: Elizabeth Layfield

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs.Helen C.Layfield(R.D.#3)Delmar Rd Address: Salisbury,Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Atelectasis
773.5
DUE TO
(b) Prematurity
DUE TO
(c) Hyperhydramnios

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. N/A 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A
20f. (City or town) (County) (State) N/A

21. I **certify** that (I) (this hospital) attended the deceased from 18 2:10A.M. Mo. 19, that (I) (we) last saw the deceased alive on 19, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE: Wm B Smith M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: May 5 /1961
22c. PHYSICIAN'S NAME (Type): Dr.William B.Smith
22d. ADDRESS: Salisbury,Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 6,1961
23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
23d. LOCATION (City, town, or county) (State): Salisbury,Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY ADDRESS: SALISBURY MARYLAND
25a. REC'D BY REGISTRAR DATE MAY 9 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Travers

VR A1S (4) 1SM 9/59

2082345XV3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6211

CERTIFICATE OF DEATH

Reg. Dist. No. 06198

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 1 WEEK
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): POCOMOKE CITY
d. STREET ADDRESS: 605 SECOND ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2342-2

082

3. NAME OF DECEASED (Type or print): First STANLEY Middle P. Last LAMBDEN

4. DATE OF DEATH: Month MAY Day 25 Year 1961

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: SEPT. 16, 1889
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALESMAN
10b. KIND OF BUSINESS OR INDUSTRY: INSURANCE
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ROBERT JAMES LAMBDEN
14. MOTHER'S MAIDEN NAME: ELLA JOHNSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): W.W. #1
16. SOCIAL SECURITY NO.: 213-18-4973
INFORMANT: MRS ZELLA LAMBDEN, Address 605 SECOND ST. POCOMOKE CITY, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Spontaneous Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Coma
DUE TO (b)
DUE TO (c)

330 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 5-19, 1961, to 5-25, 1961, that I last saw the deceased alive on 5-25, 1961, and that death occurred at 4:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wilbur R. Ellis Jr. M.D. ADDRESS (Street, city or town, state): Salisbury, Md. DATE SIGNED: 5-25-61

PHYSICIAN'S NAME (Type): WILBUR R. ELLIS JR.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 5-27-61
22c. NAME OF CEMETERY: BETHANY METHODIST
22d. LOCATION (City, town, or county) (State): POCOMOKE CITY, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: Robert H. Watson ADDRESS: POCOMOKE CITY, MD.
24a. REC'D BY REGISTRAR DATE: MAY 29 '61
24b. REGISTRAR'S SIGNATURE: Catherine E. Kramer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

6212

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06199

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rt 1 Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OAKLEAF Dr. Rt 1 Salisbury
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ELMER Middle: MURRAY Last: LEWIS
4. DATE OF DEATH: Month: MAY Day: 12 Year: 1961
5. SEX: MALE
6. COLOR OR RACE: Cau
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 10, 1882.
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months: 5 Days: Hours: Min.
IF UNDER 24 HRS.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret Merchant
10b. KIND OF BUSINESS OR INDUSTRY: Gen Merchandise
11. BIRTHPLACE (State or foreign country): Parksley Va.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: William H. Lewis (Dec)
14. MOTHER'S MAIDEN NAME: Arintha Barnes (Dec)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs E J Lewis — Address: Parksley, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.
DUE TO (b) Diabetic nephrosclerosis — ?
DUE TO (c) Diabetes mellitus
260X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c): Diabetic gangrene, toes, generalized arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from Feb. 17, 1961, to MAY 12, 1961, that (I) ~~(we)~~ last saw the deceased alive on MAY 10 1961, and that death occurred at 9:50 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Robert T. Adkins M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: May 12, 1961
22c. PHYSICIAN'S NAME (Type): Robert T. ADKINS
22d. ADDRESS: FRUITLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/14/61
23c. NAME OF CEMETERY OR CREMATORY: Liberty
23d. LOCATION (City, town, or county) (State): Parksley, Va.
24. FUNERAL DIRECTOR'S SIGNATURE: J. Richard Johnson — ADDRESS: Parksley, Va.
25a. REC'D BY REGISTRAR DATE MAY 17 '61
25b. REGISTRAR'S SIGNATURE: Arthur E. Krantz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6213 — 06200

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 42 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): DEER'S HEAD STATE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge, Maryland
d. STREET ADDRESS: Rt. 2, Stone Boundary Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Julia — Middle: Ann — Last: McKinley

4. DATE OF DEATH: Month: May — Day: 29 — Year: 19 61

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1883
9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (County & State, or foreign country): Unknown
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: -
14. MOTHER'S MAIDEN NAME: -

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): --
16. SOCIAL SECURITY NO.: --
17. INFORMANT: Deer's Head Hospital Records, Salisbury, Md. — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease, Decompensated — 3 weeks
DUE TO (b) Arteriosclerosis, general and cerebral — Years
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): (1) Lues; (2) Decubitus ulcers, severe

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April 17, 19 61 to May 29, 19 61, that (I) (we) last saw the deceased alive on May 29, 1961, and that death occured at 10:27 AM, from the causes and on the date stated above.

22a. SIGNATURE: V Juerman. M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 5/31/61
22c. PHYSICIAN'S NAME (Type): V. Juerman, M. D.
22d. ADDRESS: Deer's Head State Hospital, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): 6/1/61
23b. DATE THEREOF
23c. ~~NAME OF CEMETERY OR CREMATORY~~: U of Md - Med. School
23d. LOCATION (City, town or county) (State): Baltimore Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS
25a. REC'D BY REGISTRAR — DATE: JUN 5 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6214 Items 13 & 14 Film 0288 5/29/61 mh 06201

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 2 Wks.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 110 W. Locust St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle ARNOLD Last MILES
4. DATE OF DEATH: Month 5 Day 22 Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov.30,1879
9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Electrican
10b. KIND OF BUSINESS OR INDUSTRY: Repair Man
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Alfred S.Miles
14. MOTHER'S MAIDEN NAME: Elizabeth Byrd
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Harry R. Hearn, Same — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic heart Disease.
420.0
DUE TO (b) Senility
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 9-2, 1955, to 5-22, 1961, that (I) (we) last saw the deceased alive on 5-22 1961, and that death occurred at 2:25 A.M. from the causes and on the date stated above.

22a. SIGNATURE: A C Mitchell M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5-23-1961
22c. PHYSICIAN'S NAME (Type): Dr. Andrew C. Mitchell
22d. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-25-61
23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
23d. LOCATION (City, town, or county) (State): Salisbury, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hill & Johnson Co. Salisbury, Maryland
25a. REC'D BY REGISTRAR — DATE: MAY 25 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

Norman T. Baker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6215

CERTIFICATE OF DEATH

Reg. Dist. No. 6202

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke 19X-2
d. STREET ADDRESS: P.O. Box
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

082

3. NAME OF DECEASED (Type or print): First: William; Middle:; Last: Moore

4. DATE OF DEATH: Month: May; Day: 5; Year: 1961

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: APRIL 15 1886

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: FARM

11. BIRTHPLACE (State or foreign country): N.C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Sidney Moore

14. MOTHER'S MAIDEN NAME: Caroline ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Jennie Moore — Address: Manokin, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 months
420.0
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pneumonitis acute & Cerebral Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

0

21. I certify that I attended the deceased from April 17 61, 19, to May 5, 1961 that I last saw the deceased alive on May 4, 1961, and that death occurred at 8:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE David J. Gilmore M.D. **ADDRESS** (Street, city or town, state) Salisbury, Md. **DATE SIGNED** May 5, 1961

PHYSICIAN'S NAME (Type)

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5-8-61

22c. NAME OF CEMETERY OR CREMATORY: Findly Chapel

22d. LOCATION (City, town, or county) (State): Pocomoke, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar Wharton — **ADDRESS**: New Church, Va.

24a. REC'D BY REGISTRAR DATE MAY 9 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6216 Reg. Dist. No. 16203

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 2 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Delaware b. COUNTY: Sussex
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Blades
d. STREET ADDRESS: 16 West Third Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

M

082

3. NAME OF DECEASED (Type or print): First IVA Middle FRANCES Last O'Neal

4. DATE OF DEATH Month MAY Day 1 Year 1961

5. SEX Female **6. COLOR OR RACE** White **7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH August 24, 1893

9. AGE (In years last birthday) 67 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Delaware
12. CITIZEN OF WHAT COUNTRY? USA

I

13. FATHER'S NAME: Elijah Bradley
14. MOTHER'S MAIDEN NAME: Euphimia Phillips

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ******
16. SOCIAL SECURITY NO.: 216-07-9208
INFORMANT: Mrs. Arnette F. Baker Address: 19 E. Fourth St Blades, Delaware

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 6 month
DUE TO
(b) Chronic Pyelonephritis — about 2 yrs
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 9/20, 1960, to May 1, 1961, that I last saw the deceased alive on May 1, 1961, and that death occurred at 9:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE David J. Gilmore M.D. ADDRESS (Street, city or town, state) Salisbury Md. DATE SIGNED 5/1/61

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 4, 1961
22c. NAME OF CEMETERY OR CREMATORY: Blades Cemetery
22d. LOCATION (City, town, or county) (State): Blades, Delaware

23. FUNERAL DIRECTOR'S SIGNATURE: Rupert M. Watson ADDRESS: Seaford, Delaware
24a. REC'D BY REGISTRAR DATE MAY 3 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

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6217

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06204

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pittsville
c. LENGTH OF STAY IN 1b: 25 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pittsville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES — Middle FRANKLIN — Last PARKER

4. DATE OF DEATH: Month 5 — Day 18 — Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 24, 1890
9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

I

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~Farmer~~ Retired Farmer Own Farm
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jonathan Parker
14. MOTHER'S MAIDEN NAME: Annie Bailey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Nellie F. Parker, Same — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion (died immediately) — INTERVAL BETWEEN ONSET AND DEATH
420.1
DUE TO
(b) Hypertension, arteriosclerosis
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 1950, 19__, to 5-18-61, 19__, that (I) (we) last saw the deceased alive on 5-16, 1961, and that death occurred at 1 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Frank Lewis M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5-19-1961
22c. PHYSICIAN'S NAME (Type): Dr. Frank R. Lewis
22d. ADDRESS: Willards, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-21-1961
23c. NAME OF CEMETERY OR CREMATORY: Pittsville, Cemetery
23d. LOCATION (City, town, or county) (State): Pittsville, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Hill & Johnson Co. Salisbury, Maryland — ADDRESS
25a. REC'D BY REGISTRAR: DATE MAY 22 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

Norman F. Baker

VR A1S (4)
1SM 9/59

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FOR STATE HEALTH DEPT.

M

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6218 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 06205

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): D.O.A. Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Pittsville
d. STREET ADDRESS: Box 61
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Richard Middle: Thomas Last: Parsons

4. DATE OF DEATH: Month: 5 Day: 2 Year: 19 61

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 11, 1941
9. AGE (In years last birthday): 19 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Lester R. Parsons
14. MOTHER'S MAIDEN NAME: Della Truitt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give were or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Father: Mr. Lester Parsons
Address: Pittsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Traumatic pneumothorax- left
DUE TO
(b) Puncture wound of chest.
DUE TO
(c)

816 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Minutes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
Driver of car involved in two car collision.
20c. TIME OF INJURY: Hour 6:30 e.m. p.m. Month, Day, Year: 5-2-61
20d. INJURY OCCURRED: While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town): Salisbury (County): Wicomico (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Earl L. Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 407 Camden Ave. Salisbury, Md.
DATE SIGNED: 5-4-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-5-61
22c. NAME OF CEMETERY OR CREMATORY: Perdue Cemetery
22d. LOCATION (City, town, or country): Powellville, Md. (State):

23. FUNERAL DIRECTOR: Holloway and Co.
ADDRESS: Salisbury, Md.

24a. REC'D BY REGISTRAR: DATE MAY 9 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6219

Reg. Dist. No. 06206

1. PLACE OF DEATH a. COUNTY: WICOMICO — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY

c. LENGTH OF STAY IN 1b: 3 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: DELAWARE b. COUNTY: SUSSEX

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DELMAR

d. STREET ADDRESS: R710. 46X-3

e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

082

3. NAME OF DECEASED (Type or print): First FRANKLIN Middle McKINLEY Last PUSEY

4. DATE OF DEATH Month MAY Day 19 Year 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☑ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 4-5-1901

9. AGE (In years last birthday): 60 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER

10b. KIND OF BUSINESS OR INDUSTRY: WOOD

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: GEORGE PUSEY

14. MOTHER'S MAIDEN NAME: ANNE QUILLEN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 214-12-5380

INFORMANT: DELENA PUSEY — Address: DELMAR DEL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Artery Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days

420

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 16, 1961, to May 19, 1961, that I last saw the deceased alive on May 19, 1961, and that death occurred at 4:45 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: David J. Gilmore M.D. — ADDRESS (Street, city or town, state): Salisbury, Maryland — DATE SIGNED: May 19, 1961

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5-21-61

22c. NAME OF CEMETERY ~~OR CREMATORY~~: Mt Pleasant

22d. LOCATION (City, town, or county) (State): Laurel, Del.

23. FUNERAL DIRECTOR'S SIGNATURE: W. S. Marvel Co. — ADDRESS: Delmar Del

24a. REC'D BY REGISTRAR DATE MAY 22 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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6220

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06207

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: Since 4/24/61
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pine Bluff State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Denton — 05X-2
d. STREET ADDRESS: Hobbs Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Stanley — Middle: - — Last: Reed
4. DATE OF DEATH: Month: May — Day: 17 — Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7/25/1891
9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Caroline Co., Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Clem Reed
14. MOTHER'S MAIDEN NAME: Catherine Buckmaster

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Records of Pine Bluff State Hospital — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 1 year
002X
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 24, 1961, to May 17, 1961, that (I) (we) last saw the deceased alive on May 17, 1961, and that death occurred at 9 PM, from the causes and on the date stated above.

22a. SIGNATURE: E. P. Ritchings M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED: 5/18/61
22c. PHYSICIAN'S NAME (Type): E. P. Ritchings
22d. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 20, 1961
23c. NAME OF CEMETERY OR CREMATORY: Denton
23d. LOCATION (City, town, or county) (State): Denton Md

24. FUNERAL DIRECTOR'S SIGNATURE: J. Virgil Andrews Son Denton — ADDRESS:
25a. REC'D BY REGISTRAR — DATE: MAY 22 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kness

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 6287 5/22/61 mh

6221

CERTIFICATE OF DEATH

Reg. Dist. No. 06208

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crisfield
d. STREET ADDRESS: 19X2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: L. — Last: RICKETTS
4. DATE OF DEATH: Month: MAY — Day: 13 — Year: 1961
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 4 1878
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watchman
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Crisfield Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Ricketts
14. MOTHER'S MAIDEN NAME: Esther Bennett
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
INFORMANT: Willie Bennett — Address: Crisfield Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 day?
540-8
DUE TO (b) Peritonitis — 7 days?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Perforated peptic ulcer — 7 days?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): ASCVD
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9 May, 1961, to 13 May, 1961, that I last saw the deceased alive on 13 May, 1961, and that death occurred at 1:30 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Alfred W. Grigoleit M.D. — ADDRESS (Street, city or town, state): Peninsula General Hospital — DATE SIGNED: 5/13/61

PHYSICIAN'S NAME (Type): ALFRED W. GRIGOLEIT

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-15-61
22c. NAME OF CEMETERY OR CREMATORY: Crisfield Cemetery
22d. LOCATION (City, town, or county) (State): Crisfield Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Lewis R. Milbourne — ADDRESS: Princess Anne Md
24a. REC'D BY REGISTRAR: DATE MAY 18 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6222

CERTIFICATE OF DEATH

Reg. Dist. No. 06209

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 12 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mardela
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: John Middle: Edgar Last: Robinson

4. DATE OF DEATH Month: May Day: 8 Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: 5/12/1881

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Owner

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Charles W. Robinson

14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

INFORMANT: Charles Robinson, Address: Mardela, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Bronchopneumonia — 1 wk

DUE TO (b) Pulmonary Infarctions, Multiple — 1 wk

DUE TO (c) Cirrhosis of liver with ascites — years

581.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Malnutrition.

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/26, 1961, to May 8, 1961, that I last saw the deceased alive on May 7, 1961, and that death occurred at 1:45 p.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: Rufus S. Gardner, Jr. M.D. — ADDRESS (Street, city or town, state): Pinebluff Road — DATE SIGNED: 5/8/61

PHYSICIAN'S NAME (Type): Rufus S. Gardner, Jr. — Salisbury, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial **22b.** DATE THEREOF: 5/10/61 **22c.** NAME OF CEMETERY OR CREMATORY: Turner's Cem. **22d.** LOCATION (City, town, or county) (State): Nanticoke, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: O. W. Messick — ADDRESS: Bivalve, Md.

24a. REC'D BY REGISTRAR DATE: MAY 12 '61 **24b.** REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

FOR STATE HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM2. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6223

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06210

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Wicomico River

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 685 Fitzwater St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Brock — Middle: Lamont — Last: Satchell

4. DATE OF DEATH: Month: 5 — Day: 6 — Year: 19 61

5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 4, 1948
9. AGE (In years last birthday): 12 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Rogest Myers
14. MOTHER'S MAIDEN NAME: Mrs. Mary Satchell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): X
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mother: Mrs. Mary Jones — Address: Fitzwater St. Salisbury Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Drowning — INTERVAL BETWEEN ONSET AND DEATH: Sudden
929.8
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Fell from pier pilings while fishing.
20c. TIME OF INJURY: Hour 6:30 a.m. p.m. — Month, Day, Year: P.M. 5-1-61
20d. INJURY OCCURRED: While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Wicomico River
20f. (City or town): Salisbury (County): Wicomico (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 5-14-61

EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 407 Camden Ave. Salisbury, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 10, 1961
22c. NAME OF CEMETERY OR CREMATORY: green acres
22d. LOCATION (City, town, or country): Salisbury (State): Md.

23. FUNERAL DIRECTOR: Clinton F. Stewart — ADDRESS: Salisbury Md.
24a. REC'D BY REGISTRAR — DATE: MAY 22 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

1

FOR STATE HEALTH DEPT.

M

I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6224

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06211

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 22 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 209 W. COLLEGE AVE.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
d. STREET ADDRESS: 209 W. COLLEGE AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BERNICE — Middle BUNDICK — Last SHOCKLEY
4. DATE OF DEATH: Month 5 — Day 30 — Year 1961
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: DEC. 24, 1894
9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JOHN BUNDICK
14. MOTHER'S MAIDEN NAME: EMMA SHRIEVES
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO — (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: E.E. SHOCKLEY — Address: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary thrombosis
420.1
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Philip A. Insley M.D.
EXAMINER'S NAME (Type): Philip A. Insley
Address (Street, city, town, or county):
DATE SIGNED: 5-31-61

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 6-2-1961
22c. NAME OF CEMETERY OR CREMATORY: WIC. MEM. PARK
22d. LOCATION (City, town, or country) (State): SALISBURY, MARYLAND

23. FUNERAL DIRECTOR: HILL & JOHNSON CO., SALISBURY, AMRYLAND
ADDRESS: GEORGE C. HILL, II
24a. REC'D BY REGISTRAR: DATE JUN 2 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6225

CERTIFICATE OF DEATH

Reg. Dist. No. 06212

1. PLACE OF DEATH a. COUNTY: Wi comico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: All his life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 608 West Isabella St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 608 West Isabella St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Stanley Middle: E. Last: Shockley
4. DATE OF DEATH: Month: 5 Day: 22 Year: 1961
5. SEX: M
6. COLOR OR RACE: AA
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 23, 1918
9. AGE (In years last birthday): 42 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Building
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Hearl Shockley
14. MOTHER'S MAIDEN NAME: Essie Hayman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW #2
16. SOCIAL SECURITY NO.: 217-10-2452
INFORMANT: Mrs. Essie Mason, Salisbury, Md Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 Week
DUE TO
(b) Left Ventricular Hypertrophy — Indefinite
DUE TO
(c)

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 15, 1961, to May 22, 1961, that I last saw the deceased alive on May 22, 1961, and that death occurred at 5:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: E. Purnell, M.D. ADDRESS (Street, city or town, state): 652 W Main Salisbury Md DATE SIGNED: May 22 1961

PHYSICIAN'S NAME (Type): E. A. Purnell, M.D. 657 West Main St., Salisbury, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/28/61
22c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cem
22d. LOCATION (City, town, or county) (State): Fruitland, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Thornton B. Jolley, Salisbury, Md ADDRESS
24a. REC'D BY REGISTRAR DATE: MAY 29 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

1

FOR STATE HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6226

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06213

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin
d. STREET ADDRESS: Route # 3
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Derick; Middle: A; Last: Spence
4. DATE OF DEATH: Month: 5; Day: 22; Year: 61 (19)
5. SEX: M
6. COLOR OR RACE: C
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 11-24-58
9. AGE (In years last birthday): 2 yrs. IF UNDER 1 YEAR: Months: ; Days: IF UNDER 24 HRS.: Hours: ; Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): child
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Robert Spence
14. MOTHER'S MAIDEN NAME: Maggie Bridell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Father: Robert Spence, Address: Berlin, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Second and third degree burns 80% body surface. — INTERVAL BETWEEN ONSET AND DEATH: 10 hours
916.0
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Child trapped in burning house.
20c. TIME OF INJURY: Hour and Month, Day, Year: 6 P.M. 5-21-61
20d. INJURY OCCURRED While at work [ ] Not While at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): House
20f. (City or town): Berlin (County): Worcester (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X] and in my opinion death resulted from: Natural causes [ ], Accident [X] Suicide [ ], Homicide [ ], Undetermined manner [ ]

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

ACTUAL SIGNATURE: Earl L. Royer, M.D.
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 407 Camden Ave. Salisbury, Md.
DATE SIGNED: 5-23-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/23/61
22c. NAME OF CEMETERY OR CREMATORY: Evergreen Cem.
22d. LOCATION (City, town, or county): Berlin. (State): Maryland

23. FUNERAL DIRECTOR: Thronton B. Jolley, Salisbury, Md
ADDRESS:
24a. REC'D BY REGISTRAR: MAY 29 '61
DATE: MAY 29 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

Arthur S. Krauss

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6227 Reg. Dist. No. 06214

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

c. LENGTH OF STAY IN 1b: 3 Days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Worcester

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City. 23422

d. STREET ADDRESS: R.F.D. #2 Bunting Rd.

e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Amelia Middle: Baines Last: Taylor

4. DATE OF DEATH Month: May Day: 13 Year: 1961

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: May 1, 1908

9. AGE (In years last birthday): 53 yrs.

IF UNDER 1 YEAR: Months | Days — IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic.

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Exmore, Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ennis Baines

14. MOTHER'S MAIDEN NAME: Florence Brickhouse

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-34-7641

INFORMANT: Frank Taylor Address: R.F.D. #2 Bunting Rd Pocomoke

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: unknown

002X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5-10, 1961, to 5-13, 1961, that I last saw the deceased alive on 5-13, 1961, and that death occurred at 5:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William R. Ellis, Jr. M.D. ADDRESS (Street, city or town, state): Salisbury, Md. DATE SIGNED: 5-13-61

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5-17-61

22c. NAME OF CEMETERY OR CREMATORY: Ebenezer Bapt. Cem.

22d. LOCATION (City, town, or county) (State): Wardtown, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar Wharton — ADDRESS: New Church, Va.

24a. REC'D BY REGISTRAR DATE: MAY 16 '61

24b. REGISTRAR'S SIGNATURE: Arthur E. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6228

CERTIFICATE OF DEATH

06215

Item 6 Film G287 5/24/61 iwk

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury, Maryland
c. LENGTH OF STAY IN 1b: 1 month
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Princess Anne, Maryland
d. STREET ADDRESS: 23 Beechwood 19 x-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Cora — Middle: Hadey — Last: Thomas

4. DATE OF DEATH: Month: May — Day: 13 — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: July 22, 1870

9. AGE (In years last birthday): 90 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Simcox

14. MOTHER'S MAIDEN NAME: Elizabeth Dunn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Bessie Carey — Address: Princess Anne, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombois (recurrent) — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO (b) Arteriosclerosis, general. — years
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

332X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 13, 1961, to May 13, 1961, that (I) (we) last saw the deceased alive on May 13, 1961, and that death occured at 6 P.M. from the causes and on the date stated above.

22a. SIGNATURE: L. Maldve, M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: May 14, 1961

22c. PHYSICIAN'S NAME (Type): L. Maldve, M.D.

22d. ADDRESS: Deer's Head Hospital Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: 5-17-1961

23c. NAME OF CEMETERY OR CREMATORY: Manokin Presbyterian

23d. LOCATION (City, town or county) (State): Cem. Pr. Anne, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Leon R. Wilson

ADDRESS: Princess Anne, Md.

25e. REC'D BY REGISTRAR DATE: MAY 22 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6229

CERTIFICATE OF DEATH

Reg. Dist. No. 06216

M

1. PLACE OF DEATH
a. COUNTY Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
d. STREET ADDRESS 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: Lisa Middle: Louise Last: Trader

4. DATE OF DEATH Month: May Day: 5 Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 4 1961
9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours ✓ Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

I

13. FATHER'S NAME: Ralph Trader
14. MOTHER'S MAIDEN NAME: Letha White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Atelectasis
DUE TO (b) Prematurity
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 762.5

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 5/5, 1961, to 5/5, 1961, that I last saw the deceased alive on 5/5/61, 19____, and that death occurred at 8 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Wm B Smith M.D. ADDRESS (Street, city or town, state) Med. Center Salisbury Md. DATE SIGNED 5/5/61

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF May 6, 1961
22c. NAME OF CEMETERY OR CREMATORY St. John
22d. LOCATION (City, town, or county) (State) Deal Island Md.

23. FUNERAL DIRECTOR'S SIGNATURE James Lemmon ADDRESS Princess Anne Md.
24a. REC'D BY REGISTRAR DATE MAY 8 '61
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

2082332XVC

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6230 — Atoms 8 wg9. Per Birth cert date of 1/4/1960 — 06217

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1h
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 516 Tangier St

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 516 Tangier St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

12 / 1

3. NAME OF DECEASED (Type or print): First Sherionie — Middle ~~XXXXXXXX~~ — Last Tucker

4. DATE OF DEATH: Month 5 — Day 4 — Year 19 61

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: ~~12/31/60~~ Jan. 4, 1960

9. AGE (In years last birthday): 54 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ——————

10b. KIND OF BUSINESS OR INDUSTRY: ——————

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Showell

14. MOTHER'S MAIDEN NAME: Gloria Tucker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) ——————

16. SOCIAL SECURITY NO. (If yes give year or dates of service) ——————

17. INFORMANT: Gloria Tucker, Address: Salisbury, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Interstitial pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: Hours

525 X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☑, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Mayer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

EXAMINER'S NAME (Type): Earl L. Mayer

Address (Street, city, town, or county)

DATE SIGNED: 5-4-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/6/61

22c. NAME OF CEMETERY OR CREMATORY: Green Acre Cem.

22d. LOCATION (City, town, or country) (State): Salisbury, Md

23. FUNERAL DIRECTOR: Thornton B. Jolley, Salisbury, Md

ADDRESS

24a. REC'D BY REGISTRAR DATE MAY 15 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Travers

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

BP

2082462 X V4

1

6231

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06218

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar
c. LENGTH OF STAY IN 1b: 6o yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 5 East Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar
d. STREET ADDRESS: 5 East Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ADELIA — Middle ELLA — Last VINCENT
4. DATE OF DEATH: Month May — Day 28th — Year 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 27, 1873
9. AGE (In years last birthday): 87 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Delaware
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): -----
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Vincent Waller, Delmar, Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs
420.1
DUE TO
(b) Coronary occlusion — 4 hrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c) coronary arteriosclerosis — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerosis generalized.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ——— 19 46, to May 29, 1961, that (I) (we) last saw the deceased alive on May 28 1961, and that death occurred at 2 P.M. from the causes and on the date stated above.

22a. SIGNATURE: L. V. Sohler M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Dr. L. V. Sohler
22d. ADDRESS: Delmar, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olive
23d. LOCATION (City, town, or county) (State): Delmar, Del.

24. FUNERAL DIRECTOR'S SIGNATURE: W. S. Morris Co. — ADDRESS: Delmar, Del.
25a. REC'D BY REGISTRAR DATE MAY 31 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6232

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06219

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury (Rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Dagsboro Road

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury (Rural)
d. STREET ADDRESS: Dagsboro Road
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Olive — Middle: Beulah — Last: Ward
4. DATE OF DEATH: Month: 5 — Day: 2 — Year: 19 61
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 1-11-1897
9. AGE (In years last birthday): 64 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress
10b. KIND OF BUSINESS OR INDUSTRY: Factory
11. BIRTHPLACE (State or foreign country): Mardela, Md.
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Thomas Donoho
14. MOTHER'S MAIDEN NAME: Mary Budd
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Husband: Mr. Harry Ward — Address: Dagsboro Rd. Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Compound fracture of skull: fractured cervical spine — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

816X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Driver of car involved in two car collision.
20c. TIME OF INJURY: Hour 6:30 a.m. p.m. — Month, Day, Year: 5-2-61
20d. INJURY OCCURRED: While at work [ ] Not While at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town): Salisbury (County): Wicomico (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X] & Inquiry [X] and in my opinion death resulted from: Natural causes [ ]. Accident [X]. Suicide [ ]. Homicide [ ]. Undetermined manner [ ]

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

ACTUAL SIGNATURE: Earl L. Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 407 Camden Ave. Salisbury, Md.
DATE SIGNED: 5-4-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-4-61
22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
22d. LOCATION (City, town, or country): Salisbury (State): Md.

23. FUNERAL DIRECTOR: Holloway and Co. — ADDRESS: Salisbury, Md.
24a. REC'D BY REGISTRAR: MAY 9 '61 — DATE
24b. REGISTRAR'S SIGNATURE: Carlton S. Thomas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6233

CERTIFICATE OF DEATH

06220

1. PLACE OF DEATH
a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Spring Hill Private Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 200 Saratoga Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CARRIE Middle MARIE Last WHITELOCK

4. DATE OF DEATH: Month MAY Day 20th Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 20, 1895
9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Willards, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Fredrick Mitchell
14. MOTHER'S MAIDEN NAME: Theodoria Wells

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. J. Dryden Whitelock (Husband) Address 200 Saratoga St. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Rectum — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs
DUE TO (b): with Generalized Metastasis — 1 yr
DUE TO (c):

154X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year: N/A 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): N/A
20f. (City or town) (County) (State): N/A

21. I certify that (I) (this hospital) attended the deceased from 6.17. 1958 to 5.20 1961, that (I) (we) last saw the deceased alive on 5.18 1961, and that death occurred at 1:15 P. M. from the causes and on the date stated above.

22a. SIGNATURE: H A Briele M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: May 22 / 1961
22c. PHYSICIAN'S NAME (Type): Dr. Henry A. Briele
22d. ADDRESS: Medical Center - Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 23/1961
23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
23d. LOCATION (City, town, or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY ADDRESS: SALISBURY MARYLAND
25a. REC'D BY REGISTRAR DATE: MAY 25 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6234 06221

1. PLACE OF DEATH
a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pen Gen Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Parsonsburg
d. STREET ADDRESS: In Village
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First VIRGIL Middle PRETTYMAN Last WILKINS
4. DATE OF DEATH: Month MAY Day 11th Year 19 61

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb.8,1877
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Wicomico Co.Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Elisha P.Wilkins
14. MOTHER'S MAIDEN NAME: Sarah E.Dickerson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs.Annie H.Wilkins(Wife) Address: Parsonsburg,Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: unknown
420.0
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/C
20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. N/C 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): N/C
20f. (City or town) (County) (State): N/C

21. I certify that (I) (this hospital) attended the deceased from 4-4 1961 to 5-11 1961, that (I) (we) last saw the deceased alive on 5-11 1961, and that death occurred at 6:05 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Wilbur R. Ellis Jr M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: May 13 1961
22c. PHYSICIAN'S NAME (Type): Dr.Wilber R.Ellis Jr Dr.David J.Gilmore
22d. ADDRESS: Medical Center Salisbury,Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 14,1961
23c. NAME OF CEMETERY OR CREMATORY: Parsonsburg Cemetery
23d. LOCATION (City, town, or county) (State): Parsonsburg,Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY ADDRESS: SALISBURY MARYLAND
25a. REC'D BY REGISTRAR DATE: MAY 16 '61
25b. REGISTRAR'S SIGNATURE: Arthur E. Fraze

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

FOR STATE HEALTH DEPT.

Items 18-21 Film 289
6-23-61 ams

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6235

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07376

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1 da.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Selbyville, Del. R.F.D.
d. STREET ADDRESS: 23 X 2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Aldean — Middle: Williams — Last:
4. DATE OF DEATH: Month: May — Day: 29 — Year: 1961
5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Sept 27, 1959
9. AGE (In years if last birthday): 1 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Berlin, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: Robert Williams
14. MOTHER'S MAIDEN NAME: Francis Showell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Frances Williams — Address: Selbyville, Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Poisoning
DUE TO (b): Acute poisoning by ingestion of Strychnine — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 876.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Ingested mothers low blood pressure tablets
20c. TIME OF INJURY: Hour a.m. — p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home
20f. (City or town): (County): Worc. (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Evelyn A. Insley M.D.
EXAMINER'S NAME (Type): Phillip A. Insley
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county):
DATE SIGNED: 5-25-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Buried
22b. DATE THEREOF: 5/31/61
22c. NAME OF CEMETERY OR CREMATORY: Showell Cemetery
22d. LOCATION (City, town, or country): Showell — (State): Md.
23. FUNERAL DIRECTOR: Henry W. Watson — ADDRESS: Pocomoke City, Md.
24a. REC'D BY REGISTRAR: DATE JUN 9 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6236

CERTIFICATE OF DEATH

06222

M

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 3 Wks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: Quantico Rd.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

082

3. NAME OF DECEASED (Type or print): First ERNEST — Middle ELIHU — Last WILLIAMS

4. DATE OF DEATH: Month 5 — Day 28 — Year 19 61

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Oct. 3, 1878
9. AGE (In years lost birthday): 82 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Owner
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

I

13. FATHER'S NAME: Samuel A. Williams
14. MOTHER'S MAIDEN NAME: Elizabeth Phippin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 217-36-0099
17. INFORMANT: Mr. Boyd Williams, Same — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, Acute — INTERVAL BETWEEN ONSET AND DEATH

491X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Osteoporosis - Arteriosclerotic Coronary Artery Disease

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

2

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from MAY 7, 1961, to MAY 28, 1961, that (I) (we) last saw the deceased alive on MAY 28 1961, and that death occurred at 10:25 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Thomas C. Hill Jr., M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 5-29-61
22c. PHYSICIAN'S NAME (Type): Dr. Thomas C. Hill
22d. ADDRESS: Pine Bluff Rd., Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-31-61
23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
23d. LOCATION (City, town, or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Hill & Johnson — ADDRESS: Salisbury, Maryland
25a. REC'D BY REGISTRAR: DATE JUN 2 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

Norman F. Baker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any c is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funer director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6237 06223

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Scott's Camp, Jersey Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Scott's Camp, Jersey Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Louis — Middle: — Last: Wood

4. DATE OF DEATH: Month — Day: 5-6-61 — Year: 19

5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: 9-16-1909
9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): Georgia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Not Known
14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): —
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive cardio-vascular renal disease — INTERVAL BETWEEN ONSET AND DEATH: Years
.260 X
DUE TO
(b) Diabetes Mellitus — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 407 Camden Ave. Salisbury, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 5-8-61

22a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
22b. DATE THEREOF: 5-8-61
22c. NAME OF CEMETERY OR CREMATORY: St. Anatomical Bd.
22d. LOCATION (City, town, or country): Baltimore, Md.
(State)

23. FUNERAL DIRECTOR: Thornton B. Jolley
ADDRESS: Salisbury, Md.
24a. REC'D BY REGISTRAR DATE: MAY 10 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause